CPA CONNECTICUT PHARMACISTS ASSOCIATION

Testimony before Human Services Committee
March 15, 2011

Good morning Senator Musto, Representative Tercyak and members of the Committee. My name is Margherita Giuliano. I am a pharmacist and Executive Vice President of the Connecticut Pharmacists Association, a professional organization representing close to 1,000 pharmacists in the state.

I am here today to discuss the impact that the proposals in the Governor's Budget will have on pharmacies, the Medicaid patients and the residents in the state of CT. We are strongly opposed to the recommendations because the past has demonstrated that cuts to pharmacy reimbursements are no more than "quick fix" solutions that are not sustainable and do not address the continuous increase in the prescription line item.

The Governor's budget as it impacts pharmacy has a few devastating recommendations that I would like to address today:

Medicaid Pharmacy Reimbursement Rates: ($76.3million in FY 2012/$82.7 million in FY 2013) The Governor proposes to decrease the Medicaid reimbursement for pharmacies to align with those under the state employee and retiree contract (Projections are for reimbursement to be AWP – 17 or 18.5% plus a dispensing fee reduction of $1.50; Generic reimbursement is estimated to decrease to AWP-68% plus the dispensing fee of $1.50)

What does this mean? There are two components that are used to reimburse pharmacies for prescriptions. Pharmacies are reimbursed for "cost of the drug" which currently includes a small profit, and the dispensing fee which is supposed to cover overhead costs.

Let's start with the dispensing fee.

- **FACT**: The current dispensing fee does not cover the true cost of dispensing.
- **FACT**: Vials, labels, computer software systems, salaries, utilities, cost of managing inventory, etc., all cost money and are part of the overhead that must be calculated to determine "true cost of dispensing".
- **FACT**: These costs have steadily increased **EVERY YEAR**
- **FACT**: An independent study done in 2007 by Grant Thornton reported that the actual cost of dispensing for a Medicaid patient in the State of Connecticut is $12.34. That figure is now 4 years old.
- Pharmacies accept a lower dispensing fee because there is still some profit on the drug cost side

Cost of Drug

- Reimbursement for cost of drug has been based on a benchmark, published number called Average Wholesale Price (AWP). This number is set by the pharmaceutical manufacturers.
- No pharmacy actually pays AWP for the drug. Pharmacies are given discounts off of AWP based on volume of drugs purchased, prompt pay, or even pre-pay to get a better discount.
- Current reimbursement by Medicaid for the "cost of drug" is AWP – 14%.
- Based on an AWP of $200 for brand name products, this would give the pharmacy an average profit of $12: if you decrease the AWP by 1% you will decrease the profit by $2.00. If you decrease the AWP by 4.5% as projected, you will cut the profit made by the pharmacy on a $200 drug from $12 to $3. This formula does not work in our business model and threatens the infrastructure of pharmacy in our state.
- In 2009, the US Court of Appeals, First Circuit upheld a decision by courts that the company that publishes AWP, First Data Bank, intentionally inflated the AWP by only publishing data from

one wholesaler. In September, 2009 the state of Connecticut "rolled back" the AWP by 4%. This roll back was a direct hit to the pharmacies and shook the core of our industry. This past year we have seen record layoffs and trimming in pharmacies especially those that handle Medicaid.

- The state is now asking pharmacies for another 3-4%.
- The Centers for Medicare and Medicaid Services are considering the development of a national reimbursement based on an approved and transparent methodology. As CMS moves toward a reimbursement to Actual Acquisition Cost or Average Acquisition Cost they have recognized that pharmacy dispensing fees will have to increase dramatically to ensure adequate access.

Implementation of a co-pay for Medicaid recipients: ($8.3 million savings). DSS would institute copayments for Medicaid patients of up to $3 for certain services. Hospital inpatient, Emergency Room, home health, laboratory and transportation services would be exempted. Pharmacy co-pays would be capped at $20 per month. Co-pays have been implemented before. The only thing a co-pay does is shift the burden from the state right back to the pharmacy. With the new proposed cut to dispensing fees and the implementation of co-pays, pharmacies will be filling prescriptions at a negative reimbursement. Federal law prohibits the pharmacist (or any other healthcare provider) from denying the patient their medication if the patient can't afford to pay. In private industry, however, the patient doesn't get the medication without paying the co-pay.

Revise Medicare Part D co-payment requirements for Dual Eligible clients: ($2.2 million savings) Currently, dual eligibles are responsible for paying up to $15 per month in Medicare co-pays for Part D drugs. CT is one of the few states that assists these clients in paying the cost of these co-payments. Under this proposal, clients would be eligible for paying up to $25 per month in Medicare co-pays.

If these recommendations are implemented as proposed, access to care will be an issue. If pharmacies close, the prescription volume that shifts to other pharmacies will affect access for all residents of Connecticut. The "quality" of access will not be the same. In fact, **waiting for prescriptions may become a day-long event.** The Medicaid population is a more labor intensive group of patients to serve. Historically, when the Medicaid program instituted significant changes, such as a preferred drug list, prior authorizations and co-pays (temporarily), it was the pharmacists who helped them navigate these changes. Who will service the thousands of CT residents who rely on their pharmacies for information and care, never mind the delivery services and special packaging needed so that they can continue to live independently? So there may be access – but it will be changed – for everyone.

This proposal will impact jobs in our state as well. There are approximately 153 independent pharmacies in our state. There were almost 500 - 20 years ago and almost double this amount in 1999. These pharmacies employ more than 1600 full time employees and 430 full time pharmacists. It is important to remember that pharmacies are businesses that pay taxes, employ people and support their communities. They cannot afford to remain in a program where they lose money filling prescriptions.

As you know, our organization has always worked with the legislature to help make the Medicaid program as cost efficient as possible. We have brought hundreds of millions of dollars to the table in savings and yet have never shared in the savings.

It was our hope that a new administration would bring along some policy changes in healthcare. We have worked closely on committees that created Sustinet. Our collaboration with the Department of Social Services and the UConn School of Pharmacy in the Medicaid Transformation Grant demonstrated that pharmacists can impact drug utilization and improve quality of care for Medicaid patients when they are able to meet face-to face with them and when they are appropriately reimbursed. These are the types of programs that contain costs. Perhaps not in the line item – but certainly in the overall health care expenditures. However, here we are again looking at the same method to decrease this line item – cut pharmacy reimbursement.

I am sure that many of you heard from pharmacists on this issue. The level of grassroots communication has increased dramatically this year because pharmacy has reached their tipping point. They have no more to give from their bottom line. But we do have some thoughts on how we can obtain savings without impacting the pharmacy infrastructure. We will be meeting with DSS to discuss some of these potential savings. We have also met with Secretary Barnes and he is at least open to recommendations.

The definition of insanity is doing the same thing over and over again and expecting different results. Not sure who is insane – the administration – or perhaps it's me – since I am here year after year saying the same thing and truly believing there will be different results.

Going forward, I would urge the legislature to put together a work group that will develop programs that will actually have long term savings for the prescription drug line item as well as programs that will create savings on total health care expenditures. We need to be proactive on these issues. We cannot keep reacting to budget deficits. If we had implemented just one of the programs that involve pharmacist services ten years ago, I don't believe we would be in as big a deficit as we are.

Our Association has always tried to work collaboratively with the legislature and the administration to provide innovative ideas to save money. We only ask that the Legislature and the administration continue to work with us to implement some ideas that will create the savings the state is looking for without devastating the pharmacy business and access to care. We look forward to continuing the dialogue.